STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	004352	A. BUILDING: _____ B. WING _____	07/01/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
JEWEL HOUSE	607 VIRGINIA AVE MADISON, IN 47250

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey dates: June 30 & July 1, 2014 Facility number: 004352 Provider number: 004352 AIM number: N/A Survey team: Julie Dover, RN-TC (6/30, 7/1, 2014) Rita Bitner, RN (7/1, 2014) Tammy Forthofer, RN (7/1, 2014) Census bed type: Residential: 33 Total: 33 Census payor type: Other: 33 Total: 33 Sample: 7 Jewel House was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey. Quality Review 07/02/14 by Lisa McColly	R 000		